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Lethal Pity: The Oregon Death with Dignity Act, Its Implications for the Disabled, and the Struggle for Equality in an Able-Bodied World

Mark C. Siegel*

Introduction

Everything dies. This is a fundamental truth. The maple tree in my family's backyard will eventually grow old, and new leaves will no longer grace its branches. My friend's cat, which is now just a kitten, will one day stop breathing and its heart will stop beating. On a grander scale, languages are born and forgotten. Civilizations rise and decline. Even stars go nova and become dark shadows of their former selves.

And, of course, human beings die too.

Human society has struggled with questions of life and death since the first human beings buried one of their comrades on the plains of Africa. It has developed intricate ceremonies and belief systems in an attempt to lessen the cruel finality which comes with death.¹ Poets and writers have written extensively about death, some with more vitriol than others.² Films concerning death have permeated American culture with varying degrees of

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1. Examples include Catholic wakes, Jewish mourning periods, funerals, burials, cremation, etc.

2. See, e.g., DYLAN THOMAS, *Do Not Go Gentle into That Good Night*, in COLLECTED POEMS 128 (1934).

artistic success.³ In short, death has always been an integral part of our collective psyche.

Recently, advances in medical technology have drastically changed how people view life and death. Along with these scientific advances come questions about what constitutes a desirable quality of life and what it means to die with dignity. The answers to these questions have been increasingly analyzed and intensely debated as a result of the controversy over physician-assisted suicide.⁴ A growing number of people who determine that their medical conditions either severely impair their perceived quality of life or are terminal are asking their physicians to help them end their lives.⁵

In response to these requests for physician-assisted suicide, some state legislatures have attempted to legalize the practice⁶ in an effort to prevent the criminal prosecution of those physicians who actively assist a patient in the patient's own death.⁷ Oregon is the first state, however, to pass a measure legalizing physician-assisted suicide.⁸ In passing the Oregon Death with Dignity Act,⁹

3. See, e.g., *FEARLESS* (Warner Bros. 1993); *FLATLINERS* (Columbia Pictures 1990).

4. In this Article, the term "physician-assisted suicide" is defined as the practice of physicians giving patients the means to die; it is the *patient* who must perform the actual suicide. This is not the same thing as euthanasia. Euthanasia occurs when the *physician* commits the lethal act. It should be noted that there is an important distinction between voluntary and involuntary euthanasia. Voluntary euthanasia occurs when the patient gives informed consent to die. Involuntary euthanasia occurs when the patient is unable to give consent yet is euthanized regardless.

5. See, e.g., Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-assisted Suicide and Voluntary Euthanasia*, 334 *NEW ENG. J. MED.* 303, 304 (1996) (citing a recent poll showing that 24% of the Michigan public definitely thought they might request physician-assisted suicide if it were available).

6. See William Carlsen, *State Debate Follows Oregon Suicide Vote*, *S.F. EXAMINER*, Nov. 6, 1997, at A1 (detailing efforts to legalize physician-assisted suicide in California); Sue Ellen Christian, *Right-to-Die Plan Struggling for Life*, *CHI. TRIB.*, Nov. 7, 1997, at A4 (detailing similar efforts in Michigan).

7. See Roger Worthington, *Kervorkian Verdict Won't End Assisted-Suicide Issue*, *CHI. TRIB.*, Apr. 30, 1994, at 2 (detailing one of the several prosecutions of Dr. Jack Kervorkian).

8. See David Brown, *Assisted Suicide Law Splits Oregon Doctors: Tough Rules Limit Use of Lethal Doses*, *CHI. SUN-TIMES*, Nov. 14, 1994, at 22 ("[E]nactment . . . of Oregon's 'Death with Dignity Act' represents a legal acceptance of physician-assisted suicide that is without precedent in the United States.").

The Supreme Court only recently weighed in on the issue of whether a person has a constitutionally-protected right to die in *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997). *Glucksberg* is the product of two related cases, *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) and *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996). In *Compassion in Dying*, a non-profit right-to-die group, along with

the Oregon legislature treaded into legal waters previously unexplored. The ensuing controversy over this law has permeated the nation, resulting in a fierce debate.¹⁰

One issue inescapably linked with the physician-assisted suicide debate is the impact laws such as Oregon's will have on the lives of the disabled in America. This Article examines that issue and draws conclusions regarding the legal and ethical implications of physician-assisted suicide as it relates to the civil rights of the disabled. Specifically, this Article will demonstrate that the legalization of physician-assisted suicide is fraught with uncertainty and potential for abuse. One possible result of the passage of such legislation is that physician-assisted suicide laws will eventually be broadened to include not only terminally ill individuals, but also physically and cognitively disabled individuals. The notion, which is so prevalent in American culture, that disability and a low quality of life go hand in hand may influence disabled individuals to choose legally-sanctioned suicide rather than attempt to live in a society that presents a multitude of physical and social barriers to them.

Part I of this Article discusses the treatment of the disabled in Western society from ancient times to the modern era. Part II provides a brief history of physician-assisted suicide and traces its evolution in this country and others. Part III analyzes the Oregon Death with Dignity Act, explains the important sections of this law and describes the legal challenges it recently faced. Part IV demonstrates the dangers of legalizing physician-assisted suicide and the impact it may have on the lives of the disabled. Part V offers

numerous terminally ill individuals, successfully challenged a Washington statute which criminalized assisted suicide. See *Compassion in Dying*, 79 F.3d at 793-94. The Ninth Circuit Court of Appeals ruled that the State of Washington's ban on physician-assisted suicide was unconstitutional and a violation of due process. See *id.* In *Quill*, another group of physicians and patients successfully challenged a similar statute in New York. See *Quill*, 80 F.3d at 716. In *Glucksberg*, the Court ruled that there is not a constitutional right to die. See *Glucksberg*, 117 S. Ct. at 2262-75.

This ruling does not mean that physician-assisted suicide is explicitly prohibited. Other states are free to consider their own laws regarding physician-assisted suicide. See *id.* at 2275. As the Court stated, "[t]hroughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society." *Id.*

9. OR. REV. STAT. §§ 1-6 (1995).

10. See Brown, *supra* note 8, at 22 and accompanying text; Carey Goldberg, *Oregon Braces for New Right-to-Die Fight*, N.Y. TIMES, June 17, 1997, at A12 ("Oregon may become again, and with greater intensity, the principal arena in which the thorny ethical questions surrounding [physician-assisted suicide] are translated into a knock-down, drag-out political battle.").

solutions and alternatives for addressing the underlying issues surrounding physician-assisted suicide and the effect it may have on people with disabilities.

I. The Disabled: Paternalism and Oppression

A. *Angels and Demons: The Beginnings of Oppression*

People with disabilities have always occupied a curious position in Western society. On one hand, society has viewed them as noble individuals who bear the burden of their infirmities with an angelic countenance.¹¹ On the other hand, society has regarded the disabled as pathetic and helpless creatures who have no prospects for leading normal and productive lives.¹² As a result, people with disabilities have been relegated to a secondary role in society, a role replete with overtones of dependence, paternalism and oppression.¹³

In ancient times, the disabled were generally treated as outsiders.¹⁴ The early Christians believed that the disabled were cursed by God or possessed by demons.¹⁵ The Romans, and later the Roman Catholic Church, prohibited the disabled from serving as priests.¹⁶ Although Christianity later began to take a more charitable attitude towards people with disabilities,¹⁷ the disabled were always considered to be the "other": a foreigner and a stranger, a tragedy in human form.¹⁸

11. See *Searching for Sharper Images*, PARAPLEGIA NEWS (Paralyzed Veterans of Am., Phoenix, AZ), Jan. 1997, at 55, 55 ("[The] media image [of the disabled] is still defined by telethon poster children and courageous overachievers . . .").

12. See Kathi Wolfe, *Ordinary People: Why the Disabled Aren't So Different*, THE HUMANIST, Nov.-Dec. 1996, at 31, 31 ("People see [the disabled] as beggars, helpless victims, or superheroes.").

13. See *infra* note 55 and accompanying text.

14. See HUGH GREGORY GALLAGHER, BY TRUST BETRAYED: PATIENTS, PHYSICIANS, AND THE LICENSE TO KILL IN THE THIRD REICH 31 (1990).

The medical historian Henry Sigerist discerned . . . differing social approaches toward the disabled: [t]he ancient Hebrews believed disability to be caused by sin. The ancient Greeks considered it to be a matter of status and economics—the [disabled] as social inferiors. The Christians looked upon the disabled as cursed or possessed, objects of pity and prayer.

Id.

15. See *id.*

16. See *id.*

17. See *id.* at 32.

18. See STEPHEN L. PERCY, DISABILITY, CIVIL RIGHTS AND PUBLIC POLICY: THE POLITICS OF IMPLEMENTATION 5 (1989) (pointing to such characters as Captain Ahab and the Hunchback of Notre Dame as representations of the stereotypical "evil, vengeful, and freakish" disabled individual).

B. The Early Twentieth Century: The Nazis and Aktion T-4

When Adolf Hitler and the Nazis rose to power in Germany during the 1930s, few people guessed how their actions would forever alter the debate on euthanasia and assisted suicide. Hitler possessed a vehement contempt for the disabled.¹⁹ In his book *Mein Kampf*, Hitler wrote that his Third Reich “must take care that only the healthy beget children; that there shall be but one thing shameful: to be sick and ailing, and nevertheless to bring children into the world.”²⁰ This violent hatred of the “inferior” and the “genetically tainted” directly resulted in the forced sterilization of 375,000 people between 1933 and 1939; people who were physically disabled, mentally ill or challenged, deaf, blind, alcoholic or who otherwise did not meet Hitler’s specifications of a healthy Aryan.²¹ Yet this was only a precursor to the killing that would follow.

In September 1939, Hitler signed a secret order that marked the beginning of the systematic extermination of the physically and mentally disabled in Germany.²² The killing program was known as *Aktion T-4*.²³ *Aktion T-4* was a quintessential example of Nazi brutality combined with the efficient bureaucracy of the Third Reich. Ironically, the Holocaust began where one might least suspect: in the hospitals.²⁴ The Nazis transported “qualified” patients by bus from hospitals to killing centers scattered across Germany.²⁵ Once the patients arrived at the killing centers, the Nazis brought them to a shower room and told them to wash after the long journey.²⁶ After the Nazis herded the patients into the showers, a nurse closed the door and the head physician of the fa-

19. See GALLAGHER, *supra* note 16, at 52.

20. *Id.*

21. See *id.* at 53.

22. See *id.* at 45-46. The order, written on Hitler’s personal stationary, stated that “persons who, according to human judgment, are incurable can, upon a most careful diagnosis of their condition of sickness, be accorded a mercy death.” *Id.* Hitler actually backdated the order to September 1, 1939, the day Germany invaded Poland. See *id.* at 45. This was done to give the killing program the status of a wartime order. See *id.* Hitler intended to formally legalize the program after the war. See *id.*

23. See *id.* at 57. The moniker “T-4” came from the address of the villa which served as the base of operations for the program: *Tiergartenstrasse 4*, Berlin, Germany. See *id.*

24. See *id.* at 13.

25. See *id.* at 11; *60 Minutes: Herr Doktor* (CBS television broadcast, Oct. 20, 1996) (describing the methods used by the Nazis to facilitate *Aktion T-4*) [hereinafter *60 Minutes*].

26. See GALLAGHER, *supra* note 16, at 13.

cility pushed a button to release carbon monoxide into the room, which killed the unsuspecting patients.²⁷

The Nazis killed between 100,000 and 200,000 people²⁸ before *Aktion T-4* ended in 1941. The Nazis officially discontinued the program because of growing public protest over the Nazis' treatment of the disabled, but unofficial killing continued until the end of the war in 1945.²⁹ This widespread extermination of Germany's disabled population is still a relatively unknown chapter of history,³⁰ despite the well-known history of the holocaust of Jews, Gypsies, homosexuals, and political dissidents.³¹

C. Modern Times

In modern times, the disabled continue to exist outside of mainstream society. Much of this isolation is due to society's implicit and persistent rejection of the disabled.³² These attitudes stem from several sources. One source is the depiction of the disabled in literature and media.³³ Other sources include social norms, child-rearing practices and deep-seated psychological fears or anxieties.³⁴

The discrimination arising out of these prejudices affects nearly every aspect of disabled people's lives. They are denied basic human traits as a result of society's fears and misconceptions. The mainstream culture, for example, commonly assumes that the disabled are devoid of sexuality and sexual characteristics.³⁵ Surveys on sexuality generally ignore issues relating to the disabled.³⁶ One study indicates that society has disapproving, or even nega-

27. See *id.* at 14-15. During the Nazi's official euthanasia stage, carbon monoxide was the killing method, but after this official stage, the killings continued by the method chosen by each facility's medical director. See *id.*

28. See DEREK HUMPHRY & ANN WICKETT, *THE RIGHT TO DIE: UNDERSTANDING EUTHANASIA* 20 (1986) (asserting that approximately 100,000 people were killed due to *Aktion T-4*); *60 Minutes*, *supra* note 25 (stating that over 200,000 people were killed as a result of *Aktion T-4*).

29. See GALLAGHER, *supra* note 14, at 15.

30. See *id.* at 5 ("The world has largely ignored the issue of what the German physicians did to their patients during World War II.").

31. See *id.* at 51-53; *60 Minutes*, *supra* note 25.

32. See Wolfe, *supra* note 12, at 31 (citing a recent Harris poll which showed that 47% of Americans are fearful of the disabled).

33. See PERCY, *supra* note 18, at 5.

34. See *id.* at 5-6 (citing a review of studies that examined the formation of attitudes toward disabled people).

35. See Yvonne Duffy, *Our Sexual Rights*, *INDEPENDENT LIVING*, Sept. 1992, at 65, 68 ("[M]ost of society continues to view [the disabled] as asexual").

36. See JOHN GLIEDMAN & WILLIAM ROTH, *CARNEGIE COUNCIL ON CHILDREN, THE UNEXPECTED MINORITY: HANDICAPPED CHILDREN IN AMERICA* 364 (1980).

tive, attitudes towards the disabled expressing their sexuality.³⁷ Until very recently, physicians had even suggested that individuals with disabilities be sterilized when they reached adolescence.³⁸ Various reasons have been cited for society's perception of the disabled as asexual or impotent.³⁹ These include misconceptions that the disabled are unable to be intimate because they are locked in a perpetual "childlike" state and that they cannot participate in sexual activity for health reasons.⁴⁰

Other facets of the disabled person's life are affected by society's attitudes as well. The disabled person's effort to find employment is frustrated by employers' reluctance to hire such individuals because employers fear that special accommodations will be required or that the disabled worker will not be as productive as a "normal" worker.⁴¹ It is estimated that sixty-six percent of disabled individuals aged sixteen to sixty-four were unemployed in 1985.⁴² Internationally, the unemployment rate for disabled persons is two to three times higher than it is for other persons.⁴³

Federal and state legislatures have passed significant legislation since the 1970s that has benefited the disabled. These institutional changes have varied widely, from the provision of designated parking spots for the disabled⁴⁴ to federally-mandated programs designed to curb discrimination against the disabled.⁴⁵

37. See PERCY, *supra* note 18, at 6 (citing a study of sexually-liberated college students).

38. See, e.g., GLIEDMAN & ROTH, *supra* note 36, at 365 (relating an instance when a physician recommended to the mother of a child with Down's Syndrome that the child should be sterilized once she began to menstruate).

39. See *id.* at 365-66.

40. See *id.*

[T]he [disabled] role represents the culturally prescribed 'solution' to the misfortune of suffering from a condition that supposedly renders one indefinitely childlike. Perceiving the [disabled] as sick, it is only natural for the able-bodied to believe that they are either incapable of sex because of the 'illness,' or that they should not engage in sex because . . . sexual indulgence can slow or even prevent recovery.

Id.

41. See PERCY, *supra* note 18, at 194 (attributing employers' reluctance to "common myths and misunderstandings, which include the ideas that the employment of disabled persons will increase insurance and workers compensation costs, cause higher absenteeism among employees, reduce productivity, harm the morale and productivity of [non-disabled] workers, and require costly accommodation measures.").

42. See *id.* at 8.

43. See LEANDRO DESPOUY, UNITED NATIONS, HUMAN RIGHTS AND DISABLED PERSONS 26 (1993).

44. See, e.g., MINN STAT. § 169.345 (1996) (creating parking privileges for the physically disabled).

45. See *infra* notes 46-48.

The major federal programs which are meant to assist the disabled include the Rehabilitation Act of 1973,⁴⁶ the Individuals with Disabilities Education Act⁴⁷ and, perhaps the most significant piece of federal legislation affecting disability rights, the Americans with Disabilities Act.⁴⁸ Although these federal acts have had a dramatic impact on the lives of the disabled and have allowed them to achieve limited integration into mainstream society,⁴⁹ they have not been enough to alter society's invidious discrimination against people with disabilities.⁵⁰

These factors contribute to the social and physical isolation of the disabled. The disabled are forced into a dependent role that inhibits their social development and casts them into a paradigm that is more paternal than rehabilitative. As the authors of one book state, "[the disabled] do not develop sociologically; they remain 'unstuck in time', citizens of a therapeutic state where there are only good patients and bad patients, not grown-ups and children."⁵¹

This is simply a brief overview of how the disabled have been treated in Western civilization, particularly the United States. Volumes have been written about the sociology and psychology of disability and it is not this author's intention to reiterate the findings of others.⁵² It is critical to understand the disabled experience in order to see how the legalization of assisted suicide and euthanasia will result in the continued devaluation of people with disabilities. As one author puts it: "When society pities and fears persons with disabilities to the extent that suicide is considered a

46. See Rehabilitation Act of 1973, 29 U.S.C. § 701 (1994) (prohibiting discrimination against the physically and mentally disabled in any program which received federal funding).

47. See Individuals with Disabilities Education Act of 1970, 20 U.S.C. § 1400 (1994) (requiring that every disabled child receive "a free appropriate public education" regardless of the nature of his or her disability).

48. See Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-13 (1994). The ADA significantly expands upon the Rehabilitation Act of 1973. It prohibits discrimination against the disabled in the private sector and explicitly covers employment, transportation and public accommodations. See *id.* §§ 12112, 12141-65, 12182-84.

49. See Ruth Freedman & Sheila Fesko, *The Meaning of Work in the Lives of People with Significant Disabilities: Consumer and Family Perspectives*, 62 J. REHABILITATION 49, 49 (1996) ("Since the passage of the Americans with Disabilities Act and the Rehabilitation Amendments of 1992, there has been increased public attention to the employment of people with disabilities.").

50. See *id.* at 54.

51. GLIEDMAN & ROTH, *supra* note 36, at 261.

52. See, e.g., LEONARD J. DAVIS, ENFORCING NORMALCY: DISABILITY, DEAFNESS, AND THE BODY (1995); DISABILITY AND SOCIETY: EMERGING ISSUES AND INSIGHTS (Len Barton, ed., Longman 1996).

rational choice, it is difficult to expect that same society will have enough respect to treat such persons as truly equal."⁵³ The pity and fear are important components of a potentially deadly equation. An analysis of physician-assisted suicide and euthanasia in relation to society's attitudes about disability will reveal the sum of that equation.

II. Assisted Suicide and Euthanasia: A Historical Overview

Understanding the history of the right-to-die movement sheds light on its motivations and how it has achieved such widespread acceptance in American culture and around the world.

A. A Historical Perspective

Physician-assisted suicide and euthanasia are nothing new to human civilization.⁵⁴ The ancient Greeks had a strong tradition of embracing euthanasia⁵⁵ and hastening death.⁵⁶ Plato criticized the medical profession in his *Republic* for "educating diseases . . . and inventing lingering death."⁵⁷ The Stoics also thought highly of suicide, killing themselves for such minor physical maladies as a wrenched finger or an abscessed gum.⁵⁸ The Romans also viewed suicide as an acceptable means of ending a terminal illness or escaping dishonor.⁵⁹ By Medieval times, attitudes had changed, and suicide was strongly discouraged. The Christian Church condemned it as a crime, denying funeral rites to anyone who voluntarily ended his or her own life.⁶⁰

It was not until the Age of Enlightenment that attitudes regarding euthanasia began to shift again.⁶¹ Secular individuals, at least, no longer viewed suicide and euthanasia as evil acts worthy

53. Paul Steven Miller, *The Impact of Assisted Suicide on Persons with Disabilities—Is it a Right Without Freedom?*, 9 ISSUES L. & MED. 47, 49 (1993).

54. See, e.g., HUMPHRY & WICKETT, *supra* note 28, at 3-19 (1986) (providing a brief overview of the treatment of euthanasia throughout history and across cultures).

55. The word "euthanasia" derives from the Greek language. See *id.* at 3 (explaining that *eu* means "well" and *thanatos* means "death").

56. See *id.* at 3-4 ("When suicide was state approved, it was not only encouraged but endorsed. In Athens . . . magistrates kept a supply of poison for anyone who wished to die.") "For the Romans and Greeks, dying decently, rationally, and—not least—with dignity mattered immensely." *Id.* at 6.

57. *Id.* at 4.

58. See *id.* at 4-5.

59. See *id.* at 5.

60. See *id.* at 6.

61. See *id.* at 10 (stating that Rousseau used the term "virtuous suicide" to describe the suicide of those who were suffering and wasting away).

of condemnation. Francis Bacon argued that physicians should assist patients "to make a fair and easy passage from life."⁶²

The belief that a physician should relieve a patient from pain and suffering by means of euthanasia gained even wider acceptance during the eighteenth and nineteenth centuries.⁶³ Doctors viewed euthanasia as a means of ending the suffering of the incurable and the terminally ill;⁶⁴ they believed they helped their patients by ending their lives in a humane manner.⁶⁵

The effort to legalize assisted suicide and euthanasia continues today, both in the United States and around the world.⁶⁶ At least two countries, the Netherlands and Australia, have taken active measures to legalize euthanasia and physician-assisted suicide.⁶⁷ Although the Netherlands has allowed euthanasia and physician-assisted suicide by judicial decision since 1985,⁶⁸ the Dutch parliament adopted a law legalizing it in February 1993.⁶⁹ Prior to the adoption of the law, euthanasia and physician-assisted suicide existed in a semi-legal limbo⁷⁰ without an explicit statute or law recognizing it. Previously, the Dutch Supreme Court had essentially granted physicians the power to determine if and when it was appropriate to help a patient end his or her life.⁷¹ As a result, the criteria for euthanasia and physician-assisted suicide

62. *Id.* at 8.

63. *See id.* at 10 (citing an oral thesis delivered by Carl F.H. Marx entitled "Medical Euthanasia," in which Marx "insisted that the physician 'is not expected to have a remedy for death, but for the skillful alleviation of suffering, and he should know how to apply it when all hope has departed.'")

64. *See id.* at 11 (citing an 1889 speech to the Maine Medical Association where a physician reminded his colleagues that they should not ignore the needs of the terminally ill and that such suffering should be relieved).

65. *See id.* "The concept of physical and mental pain . . . was considered by physicians and writers as a possible justification for ending one's life." *Id.*

66. *See, e.g.,* Richard Bernstein, *French Doctors Say They Helped Patients Die*, N.Y. TIMES, Sept. 20, 1984, at A19; Martin Walker, *U.S. Court Legalises Euthanasia*, THE GUARDIAN, Mar. 8, 1996, at 3.

67. *See* Seth Myans, *Legal Euthanasia: Australia Faces a Grim Reality*, N.Y. TIMES, Feb. 2, 1997, at A3 (explaining that both Australia and the Netherlands have permissive laws concerning euthanasia).

68. *See* John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?*, 9 NOTRE DAME J.L. ETHICS & PUB. POL'Y. 407, 410 (1995) (citing to *Alkmaar*, 106 NJ 451 (H.R. 1985), the relevant court decision).

69. *See Netherlands' Parliament Votes to Allow Mercy Killings*, MINNEAPOLIS STAR-TRIB., Feb. 10, 1993, at 1A (stating that the law "brings the practice [of euthanasia] out of the dark and into the open").

70. *See* Keown, *supra* note 68, at 411 ("It is not even possible precisely to identify the legal criteria, let alone define them: the Supreme Court did not lay down a precise list and lower courts have issued sets of criteria which are far from congruent.")

71. *See id.* at 407.

were extremely vague. Despite the lack of legal clarity, euthanasia and physician-assisted suicide accounted for approximately 1.8% of all deaths each year in the Netherlands.⁷² This prevalence of euthanasia, along with public approval of the practice,⁷³ prompted the adoption of the law.⁷⁴ The twenty-eight-step guidelines require the patient to repeatedly request euthanasia of his or her own free will, to be informed about his or her condition and about alternatives to euthanasia and to "experience his or her suffering as perpetual, unbearable and hopeless."⁷⁵

Unlike the Netherlands where judicial opinion has allowed physician-assisted suicide, Australia's Northern Territory passed a law in 1995 that permits physicians to actively assist patients to die.⁷⁶ But physician-assisted suicide did not last long in Australia; the law was repealed in March 1997.⁷⁷

In the United States, efforts to legalize physician-assisted suicide have gained momentum in recent years.⁷⁸ Organizations such as the Hemlock Society and the Society for the Right to Die have substantial memberships.⁷⁹ These groups have a strong presence on the Internet,⁸⁰ and the Hemlock Society actively lob-

72. See Ute Angelique Joas, *Physician-Assisted Lethal Injection vs. the Plastic Bag: Will Euthanasia Legislation Ever Come? A Comparison of Standards in the Netherlands and the United States*, 6 TEMP. INT'L & COMP. L.J. 365, 370 (1992) (citing the Rummelink Report written by a government-appointed commission which examined the impact of euthanasia in the Netherlands). According to the Rummelink Report, doctors in the Netherlands "complied with approximately 2300 euthanasia requests and assisted 400 suicides out of 130,000 deaths each year." *Id.* at 370 n.42 (citing *Right to Die*, THE INDEPENDENT, Sept. 11, 1991, at 9).

73. See *Netherlands' Parliament*, *supra* note 69, at 15A ("About 80 percent of the Dutch people approve of euthanasia for the terminally ill, a recent opinion poll indicates.").

74. See *id.* at 1A (noting that the law "legally acknowledg[es] a practice that has been quietly accepted for years").

75. *Id.*

76. See THE LAST RIGHT?: AUSTRALIANS TAKE SIDES ON THE RIGHT TO DIE ix (Simon Chapman & Stephen Leeder eds., 1995). The official time and date of passage was 3:15 A.M. on May 26, 1995, evidence that the law had controversial beginnings. See *id.*

77. See *Australia Strikes Down Assisted-Suicide Law*, USA TODAY, Mar. 25, 1997, at A6.

78. See Goldberg, *supra* note 10, at A12 (noting that the legalization of physician-assisted suicide in Oregon will be closely watched in other states that will face the issue).

79. See Joas, *supra* note 72, at 380. The Hemlock Society has approximately 40,000 members while the Society for the Right to Die has an estimated 200,000 members. See *id.* (citing a 1990 source).

80. See, e.g., Euthanasia Research & Guidance Organization, *Euthanasia World Directory* (visited Sept. 13, 1997) <<http://www.efn.org/~ergo>> (listing links to various right-to-die topics and issues); Physicians for Mercy (visited Sept. 13, 1997) <http://www.rights.org/~deathnet/kevorkian_guidelines.html> (listing guidelines approved by an organization of Michigan doctors and specialists for

bies for legislation that would enable patients to end their lives with the legal aid of their physicians.⁸¹

III. The Oregon Death with Dignity Act and the Battle in Court

A. The Legislation

The Oregon Death with Dignity Act⁸² (ODDA) was passed in 1994.⁸³ Also known as Measure 16,⁸⁴ Oregon voters passed it with only fifty-one percent of the vote.⁸⁵ Its passage made Oregon the first state to legalize physician-assisted suicide.⁸⁶ In November 1997, Oregon voters defeated a referendum to repeal the Act by sixty percent to forty percent.⁸⁷

The ODDA has three major sections: requirements, safeguards, and immunities.⁸⁸ The requirements section explains how a physician may properly assist in a patient's suicide.⁸⁹ Two physicians must determine that a patient is terminally ill⁹⁰ before the patient may make a request for his or her attending physician to prescribe a lethal dose of medication.⁹¹ It is important to note that the physician does not actually administer the lethal dose; the pa-

physician-assisted suicide). Organizations that oppose physician-assisted suicide and euthanasia also utilize the Internet to support their movement. See, e.g., Not Dead Yet (visited Sept. 19, 1997) <<http://www.acils.com/NotDeadYet>> (webpage for an organization of disability activists who oppose assisted suicide and euthanasia).

81. See Joas, *supra* note 72, at 380.

82. OR. REV. STAT. §§1-6 (1995).

83. See *Suit Challenges Assisted-Suicide Law in Oregon*, L.A. TIMES, Nov. 25, 1994, at A26 (citing the date of passage).

84. See Carey Goldberg, *Oregon Braces for New Right-to-Die Fight*, N.Y. TIMES, June 17, 1997, at A12.

85. See Brown, *supra* note 8, at 22.

86. See *id.*

87. See Timothy Egan, *The 1997 Elections: Right to Die*, N.Y. TIMES, Nov. 5, 1997, at A26 ("In a huge turnout, perhaps the biggest in 34 years, about 60 percent of this state's voters rebuffed an effort to repeal the nation's first assisted suicide law.").

88. See OR. REV. STAT. §§ 2-6 (1995).

89. See *id.* §§ 2-3.

90. See *id.* § 1.01(12) ("A terminal illness is defined as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.").

91. See *id.* § 2.01. The section states in full:

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this Act.

tient must commit the final act.⁹² The physician provides the patient with the means to end his or her life.⁹³

The second section of the ODDA establishes procedures and safeguards.⁹⁴ The patient must follow a specific procedural process to obtain the lethal medication.⁹⁵ The patient must make an initial oral request to his or her attending physician asking for a lethal dose of medication for the purpose of ending his or her life.⁹⁶ The oral request must be followed by a written request and a second oral request, both within fifteen days of the original oral request.⁹⁷ Only after these steps have been followed may the attending physician prescribe the lethal dose.⁹⁸

There are several safeguards in the ODDA designed to prevent abuse of the Act. One safeguard is the written statement that requests assistance to die, which must be signed by two witnesses as well as the patient.⁹⁹ Furthermore, the law limits the ability of certain people to serve as witnesses.¹⁰⁰ The patient has the opportunity to rescind his or her request for assistance to die at any

Id.

92. *See id.* § 3.01(9) ("The attending physician shall . . . writ[e] a prescription for medication to *enable a qualified patient* to end his or her life in a humane and dignified manner.") (emphasis added).

93. *See id.* It is interesting that the Oregon Legislature categorizes the ODDA as something other than physician-assisted suicide. *See id.* § 3.14. "Actions taken in accordance with this Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law." *Id.* The attending physician supplies the lethal dose necessary for the patient to die, yet the State of Oregon does not consider the physician to be assisting in the suicide. Nevertheless, for the purposes of this Article, the ODDA will be treated as a form of physician-assisted suicide. This is because the physician plays an integral part in giving the patient the means to end his or her life. If the physician does not provide the patient with the means to commit suicide, the patient is forced to find other means of suicide. Essentially, the physician is the instrument which hastens death and is therefore assisting the patient's suicide.

94. *See* OR. REV. STAT. §§ 3.01-14 (1995).

95. *See id.* § 3.06.

96. *See id.*

97. *See id.*

98. *See id.*

99. *See id.* § 2.02(1). The section reads:

A valid request for medication under this Act shall be in substantially the form described in Section 6 of this Act, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

Id.

100. *See id.* §§ 2.02(2)(a)-(2)(c). Among those individuals excluded are relatives of the patient, people who stand to inherit any portion of the patient's estate, and any individuals connected to the health care facility where the patient is receiving treatment or is a resident. *See id.*

time.¹⁰¹ In addition, the physician must provide the patient with an opportunity to rescind after the second, and final, oral request.¹⁰²

There are additional safeguards worth noting. The attending physician must refer the patient to a consulting physician to confirm the terminal diagnosis and to ensure that the patient is acting voluntarily.¹⁰³ Either the attending physician or the consulting physician may refer the patient to counseling if he or she feels that the patient is suffering from a psychiatric or psychological illness or depression.¹⁰⁴ The attending physician must ask the patient to inform relatives of his or her decision to die, although the patient may refuse.¹⁰⁵ The attending physician must fully document the patient's medical condition and prognosis, as well as all of the patient's written and oral requests "to end his or her life in a humane and dignified manner."¹⁰⁶ The physician must also inform the patient of possible alternatives to suicide.¹⁰⁷

Finally, the third section of the ODDA creates specific immunities and liabilities.¹⁰⁸ Concerning immunities, the ODDA explicitly states that "[n]o person shall be subject to civil or criminal liability or professional disciplinary action for participating in good

101. *See id.* § 3.07.

102. *See id.* § 3.06.

103. *See id.* § 3.02.

104. *See id.* § 3.03 (stating that no lethal doses of medication may be prescribed until it has been determined that the patient is not suffering from a "psychiatric or psychological disorder, or depression causing impaired judgment"); *see also* Edward J. Larson, *Prescription for Death: A Second Opinion* 44 DEPAUL L. REV. 461, 469 (explaining that 90-100% of suicide victims suffer from depression, and noting that two to four percent of all suicide victims were terminally ill at the time of their death).

105. *See id.* § 3.05 ("A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.").

106. *Id.* § 3.09(1). In addition, the physician must note that he or she offered the patient the opportunity to rescind the request and that all requirements have been met. *See id.* The physician must also note the outcome of any counseling provided, the steps taken to carry out the patient's request and the medication prescribed. *See id.*

107. *See id.* § 3.01(2)(e). Possible alternatives listed in this section include hospice care and pain control. *See id.* Hospice care is usually done in the home or a hospice facility and serves to help the patient deal with the dying process. *See, e.g., Hospice: A Better Way to End a Life*, MINNEAPOLIS STAR-TRIB., May 28, 1997, at 10A (describing how hospice care prepares individuals to confront death). Pain control involves the administration of medication (such as morphine) or other techniques to manage the severe pain of some terminally ill individuals. *See, e.g.,* Gordon Slovit, *Cancer Pain is Manageable, Specialist Says*, MINNEAPOLIS STAR-TRIB., Oct. 15, 1994, at 4B (quoting a pain-management expert as stating that the "pain of terminal cancer can be made bearable or eliminated in almost every patient").

108. *See id.* §§ 4.01-02.

faith compliance with this Act. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.”¹⁰⁹ Furthermore, no health care professional may be censured or have his or her license revoked for participating in accordance with the Act.¹¹⁰

The Act also specifies liabilities for any participating physician or health care professional.¹¹¹ Any person who forges a patient’s request to die or exerts undue influence or coercion with the intent to end a patient’s life shall be guilty of a Class A felony under Oregon law.¹¹²

B. The ODDA and the Courts

Soon after Oregon voters approved the ODDA, the Act was challenged in court.¹¹³ In August of 1995, a federal district court ruled in *Lee v. Oregon*¹¹⁴ that the ODDA violated the Equal Protection Clause of the U.S. Constitution.¹¹⁵ Under the Equal Protection Clause, the state may differentiate between some classes of persons as long as the classification is related to a legitimate state interest.¹¹⁶ In *Lee*, the plaintiffs claimed that Oregon discriminated between the terminally ill and the non-terminally ill without a legitimate state interest.¹¹⁷ Specifically, the plaintiffs claimed that the ODDA denied the protection of Oregon laws¹¹⁸ to the ter-

109. *Id.* § 4.01(1).

110. *See* § 4.01(2).

111. *See id.* § 4.02 (listing civil and criminal sanctions available under the statute).

112. *See id.* §§ 4.02(1), 4.02(2); OR. REV. STAT. §161.605(1) (1996) (stating that the maximum punishment for a Class A felony is twenty years imprisonment).

113. *See Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995) (stating that the plaintiffs were a group of terminally ill patients and their physicians, all of whom opposed the new law); *see also Suit Challenges Assisted-Suicide Law in Oregon, supra* note 83.

114. 891 F. Supp. 1429 (D. Or. 1995).

115. *See* U.S. CONST. amend. XIV, § 1 (requiring that no state “deny to any person within its jurisdiction the equal protection of the laws”).

The Equal Protection Clause and its relation to physician-assisted suicide will be discussed later at greater length. *See infra* Part IV.B. A basic understanding of equal protection analysis, however, is necessary to appreciate the constitutional problems inherent to physician-assisted suicide.

116. *See, e.g., Gulf, C. & S.F. Ry. v. Ellis*, 165 U.S. 150, 165 (1897) (holding that a classification must be “based upon some reasonable ground—some difference which bears a just and proper relation to the attempted classification—and is not a mere arbitrary selection”).

117. *See Lee*, 891 F. Supp. at 1431, 1433. The plaintiffs also claimed that the ODDA violated the First Amendment right to freedom of religion and the Americans with Disabilities Act. *See id.* at 1431. However, the district court only addressed the equal protection issue. *See id.* at 1437.

118. These laws included OR. REV. STAT. § 426.070 (1996), which establishes the

minally ill.¹¹⁹ The court determined that there was no rational relation¹²⁰ between certain safeguards of the ODDA and a legitimate state interest.¹²¹ Specifically, the court referred to § 3.01 of the ODDA, which makes the attending physician the person responsible for determining a patient's mental condition.¹²² The court found that there was no mandate for the attending physician to seek the opinion of a trained psychiatrist or social worker before prescribing the lethal dose of medication for the patient.¹²³

The ODDA safeguards that prevent a terminally ill individual from committing suicide differ from the civil commitment process in which a suicidal, non-terminally ill individual is judged to be competent or incompetent.¹²⁴ In Oregon civil commitment proceedings, a trained mental health professional assesses the patient's mental status.¹²⁵ The ODDA, however, does not require such an assessment. The *Lee* court concluded that it was "unable to conceive of a set of facts [in the physician-assisted suicide context] under which it would be rational to not require mental and social evaluations by appropriately trained professionals."¹²⁶ In the eyes of the court, the status of a person as "terminally ill" should not prevent him or her from receiving the same protections as healthy individuals (namely, an assessment by a psychiatrist or social worker).¹²⁷

procedure for the civil commitment of mentally ill persons.

119. *See Lee*, 891 F. Supp. at 1438.

120. For a classic example of rational basis review, see *Railway Express Agency, Inc. v. New York*, 336 U.S. 106 (1949), which held that New York City could ban advertisements displayed on vehicles where the advertising is unrelated to the business for which the automobile is used.

121. *See Lee*, 891 F. Supp. at 1431 n.2, 1437. The District Court examined the issue using rational basis review because the plaintiffs argued the Act was not rationally related to a legitimate state interest, but the court did not specify a level of scrutiny to be applied in the future to the issue of assisted suicide. *See id.*

122. *See OR. REV. STAT. § 3.01(4)* (1995) (stating that the attending physician shall "[r]efer the patient for counseling if appropriate pursuant to Section 3.03").

123. *See Lee*, 891 F. Supp. at 1434 ("The problem is that the procedures designed to differentiate between the competent and incompetent are not sufficient.")

124. *See id.* at 1434 (describing the various commitment procedures of the state of Oregon).

125. *See OR. REV. STAT. § 426.110* (1995) ("The judge shall appoint one qualified examiner" who must be either "[a] physician licensed by the Board of Medical Examiners for the State of Oregon who is competent to practice psychiatry" or who is "[c]ertified as a mental health examiner qualified to make examinations for involuntary commitment proceedings by the Mental Health and Developmental Disability Services Division.)

126. *Lee*, 891 F. Supp. at 1436.

127. *See id.* at 1438.

The court then turned its attention to the "good faith" section of the ODDA.¹²⁸ Normally, the conduct of physicians in Oregon is measured against the general standard of care expected of physicians "in the same or similar circumstances in the [medical] community of the physician."¹²⁹ In contrast, the ODDA simply requires the attending physician to act in good faith under the law.¹³⁰ Therefore, the court decided that the ODDA creates the inference that it is irrelevant whether the physician acts reasonably and cautiously, or callously and negligently.¹³¹ According to the court in *Lee*, there is no rational justification for a difference between the standards expected of a physician treating a healthy individual and a physician treating a terminally ill patient.¹³²

In its conclusion, the court stated, "[the ODDA] withholds from terminally ill citizens the same protections from suicide the majority enjoys."¹³³ It also declared that in matters concerning physician-assisted suicide, "[the] 'good results' [of ending the suffering of some competent, terminally ill persons] cannot outweigh other lives lost due to unconstitutional errors and abuses."¹³⁴

The court issued an injunction that prevented any portion of the ODDA from taking effect.¹³⁵ As a result, the ODDA was not utilized for nearly three years. In early 1997, the Court of Appeals of the Ninth Circuit vacated the lower court's ruling after finding that the plaintiffs lacked standing.¹³⁶ The Supreme Court of the United States settled the legal battle, at least temporarily, when it allowed the Ninth Circuit's decision to stand.¹³⁷

128. See *supra* note 110 and accompanying text.

129. See *Lee*, 891 F. Supp. at 1436.

130. See OR. REV. STAT. § 4.01(3) (1995).

131. See *Lee*, 891 F. Supp. at 1437.

132. See *id.* ("The court finds that there is no set of facts under which it would be rational for terminally ill patients under Measure 16 to receive a standard of care from their physicians under which it did not matter whether they acted with objective reasonableness, according to professional standards.")

133. *Id.* at 1438.

134. *Id.* at 1439.

135. See *id.* This has been followed by renewed opposition to the ODDA in other arenas. In April 1997, the Oregon Medical Association voted to denounce the ODDA after assuming a neutral stance on the issue for the previous three years. See Goldberg, *supra* note 84, at A12. The Oregon Legislature returned the issue to the voters in November 1997 for a new vote. See Egan, *supra* note 87, at A26. The law was upheld with 60% of the vote. See *id.*

136. See *Lee v. Oregon*, 107 F.3d 1382, 1390 (9th Cir. 1997).

137. See Linda Greenhouse, *Assisted Suicide Clears a Hurdle in Highest Court*, N.Y. TIMES, Oct. 15, 1997, at A1 (explaining the Court's decision and describing how it is consistent with the Court's opinion in *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997), in which the Court decided there is no constitutional right to die).

This did not settle the issue of the ODDA's final status. In a second referendum prompted by efforts to repeal the ODDA, Oregon voters upheld the law by a significant majority.¹³⁸

IV. Analysis

A. *The Disabled and the Courts*

In *Lee v. Oregon*,¹³⁹ the district court found the ODDA unconstitutional as a violation of equal protection.¹⁴⁰ *Lee* did not specifically address how the ODDA may affect the disabled. The court's analysis, however, can be extended in order to illustrate how the Equal Protection Clause is a double-edged sword in the context of the relationship between physician-assisted suicide and the disabled.

Although Oregon is the first state to legalize physician-assisted suicide by statute, in recent years the courts and society have permitted people with severe disabilities to commit suicide.¹⁴¹ In *Bouvia v. Superior Court*,¹⁴² a young woman named Elizabeth Bouvia sought a court order to require a local hospital to administer morphine to her while she starved herself to death.¹⁴³ Bouvia was twenty-eight at the time and had severe cerebral palsy which had left her a quadriplegic.¹⁴⁴ She had suffered many personal setbacks, including desertion by her husband, a miscarriage and the inability to find the means to live independently after her parents were no longer able to care for her.¹⁴⁵ As a result of these personal tragedies, Bouvia admitted herself to a hospital for the purpose of starving herself to death.¹⁴⁶

138. See Egan, *supra* note 87, at A26.

139. 891 F. Supp. 1429 (D. Or. 1995).

140. See *id.* at 1438.

141. See *infra* notes 150-157.

142. 225 Cal. Rptr. 297 (Cal. App. 1986).

143. See *id.*; Diane Coleman, *Withdrawing Life-Sustaining Treatment from People with Severe Disabilities Who Request It: Equal Protection Considerations*, 8 ISSUES LAW & MED. 55, 55 (1992).

144. See *Bouvia*, 225 Cal. Rptr. at 299.

145. See *id.* at 300.

146. See *id.* Some might argue that Bouvia's request for the withholding of medical treatment differs substantially from the Oregon Death with Dignity Act's provision, which actively assists the individual to die (passive euthanasia versus active euthanasia). This author regards the difference as insignificant and irrelevant. The state must endorse the killing for either method to be without criminal liability. Also, the result is the same whether by act of commission or omission. This Article focuses more on state endorsement of euthanasia rather than a specific method of suicide. The Oregon Death with Dignity Act is simply one example of state action.

The California Court of Appeals granted Bouvia her request to die, stating that the "quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration."¹⁴⁷ The court reasoned that it would be unbearable for Bouvia to bear the perceived indignities of her disability for the rest of her life.¹⁴⁸ Thus, the court concluded that Bouvia had the right to die as an extension of her constitutional right to privacy.¹⁴⁹

In *McKay v. Bergstedt*,¹⁵⁰ the Nevada Supreme Court granted permission for a thirty-one-year-old quadriplegic, Kenneth Bergstedt, to have his ventilator turned off.¹⁵¹ The court's opinion described his situation as being "imprisoned by paralysis" and as requiring "a total dependency upon others."¹⁵² The opinion also stated that situations similar to that of Bergstedt's "may rob life of much of its quality."¹⁵³

Similarly, in *Georgia v. McAfee*,¹⁵⁴ a Georgia court allowed a quadriplegic, Larry McAfee, to have his ventilator turned off.¹⁵⁵

The liberty interest in the right to refuse medical treatment that will prolong life has been established. See *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261 (1990) (affirming the right to refuse medical treatment). It is beyond the scope of this Article to specifically address and refute the asserted liberty interest in the right to actively seek death. It is this author's belief, however, that the refusal of medical treatment, at least in the case of severely disabled persons, is by implication a form of suicide, rather than a "natural death," as some would believe. The reasons for this will be addressed in the sociological analysis section of this Article. See *infra* Part IV.C.

147. *Bouvia*, 225 Cal. Rprt. at 304.

148. See *id.* at 305.

Although alert, bright, sensitive, perhaps even brave and feisty, she must lie immobile, unable to exist except through physical acts of others. Her mind and spirit may be free to take great flights but she herself is imprisoned and must lie physically helpless subject to the ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness.

Id.

149. See *id.* However, Bouvia eventually chose not to die. See *Coleman, supra* note 143, at 56. ("[B]y the time the appellate decision was handed down, Ms. Bouvia's suicidal crisis had passed, and she did not carry out her plan of self-starvation."); Miller, *supra* note 53, at 58 n.43 (explaining Bouvia's eventual decision not to die).

150. 801 P.2d 617 (Nev. 1990).

151. See *id.* Kenneth Bergstedt had been a quadriplegic and ventilator-dependent since the age of 10. Apparently, he had spent most of the intervening 21 years in bed, watching television, reading and working with a voice-operated computer. His father had been his primary caretaker. When his father developed a terminal illness, Kenneth decided that he would rather die than be "under the care of strangers." *Id.* at 624.

152. *Id.*

153. *Id.* at 621.

154. 385 S.E.2d 651 (Ga. 1989).

155. See *id.*

The court stated that there was "no hope that Mr. McAfee's condition will improve with time, nor is there any known medical treatment which can improve his condition."¹⁵⁶ In other Western countries, family members who assist disabled people in dying have been granted great leniency in court, with physician-assisted suicide advocates calling for "tolerance" and "understanding."¹⁵⁷

Essentially, the courts grouped these disabled plaintiffs into the same category as the terminally ill.¹⁵⁸ It is likely that if the plaintiffs had *not* been disabled and had petitioned the court for sanctioned suicide,¹⁵⁹ they would have received suicide prevention counseling.¹⁶⁰ Because of their disabilities, however, the courts saw them as beyond any hope of having a decent quality of life and as being kept alive by "extraordinary" means.¹⁶¹

Consider the following hypothetical. A young man in his twenties, named Smith, becomes a quadriplegic after a diving accident. He is completely dependent on others for his care and daily needs. He is despondent and petitions the court to allow his physician to administer a lethal dose of medication to end his life. Smith lives in the fictional state of Polygon. The Polygon Legislature has recently passed an act which is exactly like Oregon's

156. *Id.*

157. See HUMPHRY & WICKETT, *supra* note 54, at 160.

158. See *Deel v. Syracuse V.A. Medical Ctr.*, 729 F. Supp. 231 (N.D.N.Y.1990) (ruling that a man with cancer has the right to be removed from a ventilator); *Gray v. Romeo*, 697 F. Supp. 580 (R.I. 1988) (ruling that a woman who is in a permanent vegetative state has the right to have her feeding tube removed). Note that these decisions draw no distinction between the terminally and non-terminally ill.

159. Again, the distinction between suicide and "passive euthanasia" has no meaning when it comes to people such as McAfee and Bergstedt. They are not terminally ill in any sense of the term. With proper care and equipment they could lead long and productive lives. See, e.g., John R. Bach & Margaret C. Tilton, *Life Satisfaction and Well-Being Measures in Ventilator Assisted Individuals with Traumatic Tetraplegia*, 75 ARCHIVES OF PHYSICAL MED. & REHABILITATION 626 (1994) (explaining that people who are ventilator assisted as a result of traumatic injury are generally satisfied with their lives). When someone on a ventilator chooses to have it turned off, it is the same thing as asking a doctor to administer a lethal injection. Both actions interrupt life and cause death artificially. It should not matter that a disabled person relies on mechanical aids such as a ventilator or feeding tube.

160. See JOSEPH P. SHAPIRO, *NO PITY: PEOPLE WITH DISABILITIES FORGING A NEW CIVIL RIGHTS MOVEMENT* 260 (1993) ("A nondisabled man who asked the state to help him take his life would get suicide-prevention counseling . . .").

161. See Coleman, *supra* note 143, at 65. Coleman criticizes the new definition of "natural death" for persons with disabilities by positing that such quality-of-life judgments devalue those individuals who require mechanical assistance to live. See *id.* Coleman hypothesizes that the same definition could eventually apply to people who require dialysis, pacemakers or insulin, implying that these types of medical assistance are not typically thought of as "permanently disabling." *Id.*

Death with Dignity Act. The citizens of Polygon are much more complacent than those in Oregon, however, and the law does not face any legal challenges.

Smith bases his request to die on the Polygon Death with Dignity Act, but his attorney reminds him that the PDDA only addresses the terminally ill, as does the ODDA.¹⁶² The young man decides that this classification is unreasonable and a violation of his equal protection rights. He challenges the PDDA in court, raising an equal protection claim and a demand for relief. His basic assertion is that the distinction between the terminally ill and the non-terminally ill is not rationally related to any legitimate state interest.¹⁶³ He claims he should not be denied the right to die simply because his disability is not terminal.

Will his legal challenge be successful? The United States Supreme Court has struck down other classifications which it deemed to be unreasonable.¹⁶⁴ Smith could argue that a distinction between the terminally ill and the disabled is also unreasonable. Smith might point out that the quality of life of a terminally ill individual and a severely disabled person such as himself is the same, and, therefore, the state has no legitimate reason to differentiate between the two classes. In Smith's mind, his potential for achievement and productivity might seem as limited as someone with a terminal illness. Why should the state of Polygon prevent him from dying when it is perfectly legal for his neighbor with pancreatic cancer to request physician-assisted suicide?

The court hearing Smith's case might agree with him and fulfill Smith's death wish. After all, the Supreme Court has already ruled that the disabled are not a suspect class and are therefore not worthy of heightened protection.¹⁶⁵ Classifying the disabled as a suspect class, however, would not ensure that laws such as the

162. See OR. REV. STAT. § 1.01(12) (1995).

163. See *Railway Express Agency, Inc. v. New York*, 336 U.S. 106 (1949) (holding that New York City could ban advertisements displayed on vehicles where the advertising is unrelated to the business for which the automobile is used).

164. See, e.g., *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432 (1985) (striking down a city zoning regulation which prevented the establishment of a community residence for the mentally disabled); *Craig v. Boren*, 429 U.S. 190 (1976) (holding that an Oklahoma law prohibiting the sale of 3.2% beer to males under 21 but not to females between 18 and 21 was constitutional); *Weinberger v. Weisenfeld*, 420 U.S. 636 (1975) (striking down a Social Security regulation which delivered benefits to a widow and her children if the father died, but gave benefits only to minor children if the mother died).

165. See *Cleburne*, 473 U.S. at 446 (applying a rational basis test, or, at best, a heightened rational basis test); Amy Scott Lowndes, *The Americans with Disabilities Act of 1990: A Congressional Mandate for Heightened Judicial Protection of Disabled Persons*, 44 FLA. L. REV. 417, 435 (1992).

Polygon Death with Dignity Act would be considered inapplicable to those with disabilities. When it comes to the nexus between the disabled and legalized physician-assisted suicide, the Equal Protection Clause is the quintessential double-edged sword.

B. A Legal Perspective—Equal Protection

The only Supreme Court decision to rule on the equal protection status of disabled Americans is *Cleburne v. Cleburne Living Center*.¹⁶⁶ The Court justified its decision by stating that the mentally disabled are a large and diverse class with widely varying needs and determining how the disabled are to be treated is such a "technical" question that only legislatures are competent to deal with the matter.¹⁶⁷ Nevertheless, the Court also noted that there continues to be "irrational prejudice against the mentally retarded,"¹⁶⁸ and that there is a "history of 'unfair and often grotesque mistreatment'" of the mentally disabled.¹⁶⁹ It seems that the Court wants to have it both ways; it is reluctant to grant quasi-suspect classification to the disabled but realizes that there has been serious and invidious discrimination against the disabled.¹⁷⁰

As a consequence of this failure to recognize the disabled as a suspect class, the hypothetical Smith is in murky legal territory when a court considers his petition to die. It is possible, indeed likely, that the court will consider his petition as a request to terminate his suffering rather than as a request to commit suicide.¹⁷¹ This type of judicial treatment of disabled persons who request suicide is not without precedent, as discussed above.¹⁷²

Herein lies the paradox. The Equal Protection Clause, designed to protect citizens from discrimination, is currently null and void when it comes to protecting the rights, indeed the very lives,

166. 473 U.S. 432 (1985). *Cleburne* specifically concerned individuals with cognitive disabilities, but legal experts generally agree that the Court meant to deny quasi-suspect classification to all persons with disabilities. See Lisa A. Montanaro, *The Americans with Disabilities Act: Will the Court Get the Hint? Congress' Attempt to Raise the Status of Persons with Disabilities in Equal Protection Cases*, 15 PACE L. REV. 621, 641 (1995) (discussing how *Cleburne* applies to all persons with disabilities).

167. *Cleburne*, 473 U.S. at 442-43.

168. *Id.* at 450.

169. *Id.* at 438 (quoting *Cleburne Living Ctr. v. City of Cleburne*, 726 F.2d 191, 197 (5th Cir. 1984), *aff'd in part and vacated in part*, 473 U.S. 432 (1985)).

170. For an excellent critique of the Court's indecisive approach to legal protection for the disabled, see Lowndes, *supra* note 165.

171. See Coleman, *supra* note 143, at 56 ("When considering requests for assistance in dying by persons with severe disabilities, other courts have made the same 'it's not suicide' determination.")

172. See *Bouvia v. Superior Court*, 225 Cal.Rptr. 297 (Cal. App. 1986).

of the disabled. Ultimately, the Equal Protection Clause could be used as an instrument to expand assisted suicide laws to apply to non-terminal but disabled individuals. In this current legal paradigm, it is conceivable that our fictional Smith could be successful in his request to die and that pieces of legislation, such as the ODDA, could be expanded to meet the needs of people similarly situated to Smith.

Rather than protecting the disabled from the dangers of physician-assisted suicide, the Equal Protection Clause could serve as an instrument for hastening the deaths of severely disabled individuals. Laws such as the ODDA apply only to people who are terminally ill, but this definition could easily be expanded to include people with disabilities. Ironically, granting suspect classification to the disabled would possibly make it easier for disabled individuals to claim that they are entitled to the benefits of laws such as the ODDA, benefits already enjoyed by the terminally ill.¹⁷³

C. Quality of Life—A Social Perspective

There are numerous reasons why the disabled are automatically equated with the terminally ill. Often a disability is seen as a sickness rather than an integral part of the individual.¹⁷⁴ For many, the concepts of "disability" and "dignity" are impossible to reconcile.¹⁷⁵ It is a deep-seated belief in nearly every human culture that physical or mental imperfection is something to be ashamed of, a trait that is a signifier of inherent inferiority.¹⁷⁶ Many aboriginal cultures put this belief into practice by abandoning, or even killing, their disabled brethren.¹⁷⁷ In modern Western cultures, particularly the United States, the disabled are regarded with ambivalence.¹⁷⁸ For example, a 1969 study showed that

173. As noted earlier, courts must closely scrutinize any law which might have a discriminatory effect on a suspect class. *See supra* note 175. Assuming the disabled are granted suspect classification, the government must present a compelling reason why the disabled are excluded from physician-assisted suicide laws rather than a simply rational justification. This heightened judicial scrutiny could very well extend such laws to the disabled.

174. *See Miller, supra* note 53, at 52.

175. *See id.* at 53.

176. *See id.* at 54. ("Society has a rigid code of acceptable norms in which disability, as a visible difference, is assumed to be a sign of inferiority.")

177. *See GALLAGHER, supra* note 14, at 28-30. Gallagher describes how the Inuit killed their deformed children, as well as the infanticide practiced by the Masai. *See id.* at 28-29. However, not all aboriginal cultures mistreat their disabled. For example, among the Dahomeans of Western Africa, "the state constables are selected from persons with deformities." *Id.* at 29.

178. *See id.* at 34. ("American society has both positive and negative feelings

ninety-three percent of the sample population would accept a physically-disabled person as a work partner, but only seven percent would accept that same physically-disabled person as a marriage partner.¹⁷⁹

This ambivalence has resulted in societal treatment of the disabled that is well-intentioned yet patronizing and dehumanizing. American society decided in the 1800s that its cripples should not be forced to beg on the streets; instead, it sent them to institutions where they were brutalized and isolated from mainstream society.¹⁸⁰ When the disabled began to attend public schools, they were usually sent to segregated schools where they had little or no contact with able-bodied children and where they received a substandard education.¹⁸¹ When it was time to enter the work world, the disabled were relegated to sheltered workshops,¹⁸² performing menial tasks, or else they did not work at all. In nearly every facet of life, the disabled were forced to accept the role of second-class citizens.

As a result of this ambivalence, past and present, the disabled have incorporated the mainstream's distorted view of what it means to be disabled.¹⁸³ Is it any wonder, in a culture that is so disapproving of disability, that President Franklin D. Roosevelt chose to disguise his paraplegia?¹⁸⁴ As one commentator notes, for persons who acquire a disability later in life "internalization of society's prejudice [about disability] is especially present."¹⁸⁵ This is because that individual has spent his or her entire life accepting

about the disabled.").

179. See *id.* at 36.

180. See WILLIE V. BRYAN, IN SEARCH OF FREEDOM: HOW PERSONS WITH DISABILITIES HAVE BEEN DISENFRANCHISED FROM THE MAINSTREAM OF AMERICAN SOCIETY 7 (1996) ("[S]ome families with members who had a disability considered the most appropriate action was to send them to an institution and keep them away from the public.").

181. Cf. Mike Ervin, *Getting Tough on Kids in Wheelchairs*, THE PROGRESSIVE, Nov. 1995, at 27 ("States had been shirking their responsibilities so that about a million disabled kids were receiving no education at all, let alone a segregated, inferior one.").

182. See generally Marvin Rosen et al., *Sheltered Employment and the Second Generation Workshop*, 59 J. REHABILITATION 30 (1993) (explaining the history of sheltered workshops).

183. See Miller, *supra* note 53, at 54. "The prejudice inflicted by society not only causes the community to consider life with a disability as undignified but often forces upon the disabled individual the same set of mores." *Id.* In other words, the person with the disability accepts and internalizes these stereotypes, creating a cycle of self-hate and self-pity in the disabled community. See *id.*

184. See generally HUGH GREGORY GALLAGHER, FDR'S SPLENDID DECEPTION (1986) (describing Franklin Roosevelt's efforts to hide his disability from the media and the general public).

185. Miller, *supra* note 53, at 54.

the stereotypes and prejudices regarding the disabled.¹⁸⁶ Individuals with congenital disabilities, however, are just as likely to internalize society's views of the disabled.¹⁸⁷ In a culture that links disability with helplessness and inferiority, it is nearly impossible for people with disabilities to avoid accepting these dominant stereotypes.¹⁸⁸

It is at this point, when the disabled person accepts society's prejudices, that we cross over into potentially lethal territory. The disabled person begins to grow tired of having to overcome every obstacle presented by an able-bodied society. Frustrations range from finding an accessible apartment to obtaining attendant care from an unsympathetic medical bureaucracy.¹⁸⁹ The phenomenon of increasing frustrations and growing feelings of hopelessness is sometimes referred to as "disability burnout."¹⁹⁰ The disabled person begins to consider suicide as a rational alternative to the daily struggles of living in an able-bodied world. In the case of Larry McAfee, he grew tired of being shuttled from nursing homes in Georgia to Ohio to Alabama.¹⁹¹ The depression he felt as a result of these events led to his wish for death. He was quoted as saying, "You reach a point where you just can't take it anymore."¹⁹²

The fact that many disabled individuals must rely on federal assistance programs such as Medicaid does not make matters easier. Many states are drastically cutting back these programs as cost-saving measures,¹⁹³ which has the potential of causing many disabled individuals to lose any sense of independence they have.¹⁹⁴ Disabled individuals who were previously able to live in

186. *See id.*

187. *See id.* ("With society continually reinforcing its values through discriminatory cultural practices, it becomes difficult for a person with a disability, whether acquired or congenital, not to accept that stigmatized value system.")

188. *See id.* ("People with disabilities are taught that the reason for their exclusion is their own inferiority.")

189. *See infra* notes 193-194 and accompanying text.

190. SHAPIRO, *supra* note 160, at 261, 264 (quoting clinical psychologist Carol Gill).

191. *See id.* at 285 ("[McAfee] still was destined to bounce from one nursing home to another . . .").

192. *Id.* at 262. McAfee, like Bouvia, ultimately chose not to commit suicide, however, and at last report was living independently. *See id.* at 288.

193. *See, e.g.,* Ruth Conniff, *Banishing the Disabled: Wisconsin Caps Home-Care Reimbursement*, THE PROGRESSIVE, Mar. 1996, at 20 (describing how Wisconsin placed caps on community-based services that fund many home care programs, leaving many disabled individuals facing the dire possibility of entering a nursing home).

194. *See id.* at 21 ("But there's an awful lot of young people who are going to be hurt by it They're just getting started, going back to school. They're in their own apartments and now they have to give that up.")

the community may be forced to make the transition to an institutional setting. Many will feel overwhelmed by this loss of freedom and will be unwilling or unable to find substitute care from family or friends. If the disabled are not given the means to live dignified, independent lives, some may choose to commit suicide.¹⁹⁵

The desire for death is compounded by society's tolerance and support for such a decision.¹⁹⁶ The judge who initially heard McAfee's request to die ruled that turning off his ventilator would simply allow the "injury process to take its natural course."¹⁹⁷ The judge equated living with a ventilator to having a life devoid of any meaningful quality.¹⁹⁸ The same reasoning is found in *McKay v. Bergstedt*.¹⁹⁹ There, the Nevada Supreme Court characterized Bergstedt's assisted ventilation as an "artificial life support system[] or some form of heroic, radical medical treatment."²⁰⁰ Both of these courts were apparently unaware of the fact that approximately 15,000 Americans live with a ventilator,²⁰¹ many of whom hold jobs and raise families.²⁰²

The disabled are therefore caught in a vicious cycle, which can only be made more dangerous with the addition of legislative acts such as the ODDA. Society constantly reinforces the stereotype that living with a disability is undignified and pathetic.²⁰³ Disabled individuals internalize these beliefs and begin to view themselves with pity and self-loathing.²⁰⁴ Some may choose death; if there are laws in place which permit physician-assisted suicide,

195. See *supra* notes 187-188 and accompanying text (discussing disability burnout).

196. See Miller, *supra* note 53, at 52. "Thus, when a person 'chooses' death over an 'undignified' life with a disability, the system sympathizes with that individual's plight and supports his right to die, assuming his disability is the root of his supreme despair." *Id.*

197. SHAPIRO, *supra* note 160, at 269.

198. See *Georgia v. McAfee*, 385 S.E.2d 651 (Ga. 1989) ("According to the record there is no hope that Mr. McAfee's condition will improve with time, nor is there any known medical treatment which can improve his condition."); *supra* notes 154-156 and accompanying text (reviewing the *McAfee* case).

199. 801 P.2d 617, 622-23 (Nev. 1990).

200. *Id.* at 624.

201. See SHAPIRO, *supra* note 160, at 260.

202. See, e.g., John R. Bach & Denise I. Campagnolo, *Psychosocial Adjustment of Post-Poliomyelitis Ventilator Assisted Individuals*, 73 ARCHIVES OF PHYSICAL MED. & REHABILITATION 934, 939 (1992) (stating that 39% of 148 sampled ventilator assisted individuals were married and 42% of 395 sampled ventilator assisted individuals were gainfully employed).

203. See *supra* note 183 and accompanying text.

204. See BRYAN, *supra* note 180, at 91 ("[F]eelings of inferiority and unworthiness are projected to the public by the person with a disability reinforcing societal attitudes.").

then the process will be that much easier. The courts, already expressing the belief that life with a severe disability is a life not worth living, will likely interpret these laws to include the disabled.²⁰⁵ Eventually, there could come a time when the disabled are euthanized without the individual even requesting death. For example, the family of a nonverbal boy with severe cerebral palsy might be able to request the euthanization of their child by pointing to his poor quality of life and the incredible burden he places on the family. The child will be unable to speak for himself and the courts might be all too willing to side with the parents. The sociology and psychology of disability may take a dark and lethal turn.

This concern is a realistic one; the scenario described above has already occurred. In the Netherlands, where physician-assisted suicide is permitted, there have been at least a thousand cases in which a doctor terminated a patient's life without receiving an explicit request from the patient.²⁰⁶ Of the physicians who euthanized a patient without permission, thirty-one percent stated that they did so because the patient had a "low quality of life."²⁰⁷ This trend has dangerous implications for the disabled. Dutch doctors are said to have "the duty to terminate meaningless lives."²⁰⁸ This puts added pressure on the disabled and their families. Individuals with disabilities might be seen as a burden to their families as well as a drain on society's resources. Thus, physician-assisted suicide creates an economy of death where a person's worth is measured in terms of saved expenses.²⁰⁹ What has already happened in the Netherlands could very well take place in the United States as laws like the ODDA take effect.

V. Solutions: A Road to Integration

If the disabled are to become a valued population in American society, free from the dangers of physician-assisted suicide, two courses of action must be taken. The first involves structural changes in society to deter individuals with disabilities, especially those who acquire their disability later in life, from considering suicide in the first place, and the second involves changing how disabled individuals view their role in society.

205. See *supra* Part IV.A.

206. See Keown, *supra* note 68, at 426.

207. *Id.* at 428.

208. Miller, *supra* note 53, at 55.

209. As mentioned earlier, some states are already cutting back on services for the disabled. See *supra* notes 193-194 and accompanying text.

As noted above, many people with disabilities experience isolation as a result of physical and psychological barriers that prevent them from engaging in social and recreational activities.²¹⁰ According to a Harris poll, "seventeen percent of disabled people had not eaten a meal in a restaurant, although only [five] percent of nondisabled people had avoided dining out."²¹¹ Fifty-nine percent of the disabled fear going out in public because they are afraid of being mistreated.²¹² Forty-nine percent said that their local public transit systems were inaccessible.²¹³ Physical barriers must be removed, as the ADA requires,²¹⁴ in order to give the disabled better access to the mainstream culture. If physical barriers are removed, psychological barriers will dissolve as the able-bodied population has more frequent contact with the disabled. Studies have shown that where the disabled are in a position to have regular interaction with mainstream society, many of the prejudices about the disabled become less pronounced.²¹⁵

Gainful employment is another structural area that must be addressed. Currently, many people with disabilities live in poverty because they are unable to find employment. Twenty-three percent of the disabled live with annual incomes between \$7,501 and \$15,000.²¹⁶ Seventeen percent earn even less.²¹⁷ Many disabled individuals are forced to live on public assistance.²¹⁸ Contributing to the problem is the fact that many disabled persons do not have the necessary education to find a decent job. Twenty-five percent of the disabled have never finished high school, and only sixteen percent have finished college.²¹⁹

One reason that many disabled people consider suicide is because they feel worthless and devalued because they are unable to find employment.²²⁰ Employers must begin to realize that the disabled can be productive and valuable assets. The educational sys-

210. See *supra* Part I.C.

211. See SHAPIRO, *supra* note 160, at 106.

212. See *id.*

213. See *id.*

214. See 42 U.S.C. §12182(b)(2)(iv) (1997) (requiring places of public accommodation to be free of architectural barriers).

215. See GALLAGHER, *supra* note 14, at 37. ("Observational studies of children and adults interacting with disabled children in the familiar surroundings of home, neighborhood, and integrated schoolrooms indicate that these negative perceptions can be changed.")

216. See BRYAN, *supra* note 180, at 18.

217. See *id.*

218. See *supra* notes 193-194 and accompanying text.

219. See BRYAN, *supra* note 180, at 16.

220. See *supra* notes 44-46 and accompanying text.

tem must make a greater effort to give the disabled the skills they need to survive and prosper in today's economy.

Yet another structural change involves reshaping attitudes about disability in the legal and medical professions. We have already seen the pity and disgust expressed by many judges when confronted with a severely-disabled individual.²²¹ Many health professionals have similar misconceptions about disability and quality-of-life issues.²²² It is these same people who might one day expand physician-assisted suicide to include the disabled. Therefore, it is essential that those in the legal and medical communities receive the necessary education to inform them that disability is not a biological prison. Rather, it is a way of life that can be full of joy and accomplishment when those individuals are given the necessary tools and skills, such as assistive technology and attendant care.

The second course of action concerns how the disabled view their role in society. There must be an end to the self-pity and self-hate that is so prevalent in the disabled community.²²³ For too long, the disabled have internalized society's prejudices and accepted those views in silence.²²⁴ Disability should not be seen as a sign of weakness and inferiority. Most disabled people will tell you that it is not the disability itself that is the problem, but society's construction of disability.²²⁵ It is up to the disabled themselves to tear down this construction and build a new one; one where the foundation is not composed of pity, but of tolerance and acceptance.

Conclusion

It is difficult to visualize an assisted suicide law which would not pose a threat to the lives of disabled persons, especially the se-

221. See *supra* note 151 and accompanying text; text accompanying notes 152-153.

222. See, e.g., John R. Bach, *Ventilator Use by Muscular Dystrophy Association Patients*, 73 ARCHIVES OF PHYSICAL MED. & REHABILITATION 179 (1992) (stating that 60 of 167 MDA clinics discouraged the use of mechanical ventilation and that clinic directors significantly underestimated the life satisfaction of those who were ventilator assisted); see also Amici Curiae Brief of Not Dead Yet and American Disabled for Attendant Programs Today in Support of Petitioners at 21, *Quill v. Vacco*, __ S. Ct. __ (1997) (No. 95-1858) ("As long as society, including medical professionals, demonstrates ignorance and prejudice regarding the lives of people with disabilities, no safeguards [regarding physician-assisted suicide] can be trusted to contain the torrent of discrimination that will be unleashed by lifting the ban on assisted suicide.").

223. See *supra* text accompanying notes 185-186.

224. See *id.*

225. See *supra* note 32 and accompanying text.

verely disabled. To varying degrees, measures like the ODDA, coupled with societal views of the quality of life of disabled people, inherently impede the efforts of the disabled to integrate themselves into society. By contributing to an atmosphere where the lives of the disabled already are devalued and placed in jeopardy, such laws invariably implicate equal protection concerns. This Article has provided one possible framework for addressing the problem. The Supreme Court has not ended the debate, and many states are struggling with the issue even as this article is being written. The passage of laws such as the ODDA should be of great concern to the disabled as they struggle to take their rightful place in mainstream society.